

## Middle Articles

### Mother and Baby Unit: Psychiatric Survey of 115 Cases

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This paper describes a mother and baby unit in a psychiatric hospital and presents statistical information about 115 mothers admitted with their babies, their mental illness having arisen during pregnancy or the puerperium. Certain comparisons are made with statistics published about patients admitted to other hospitals because of puerperal mental illness, some with and some without their babies. These comparisons suggest the need for an inquiry which might allow accurate assessment of the value of combined mother-baby admission in such illnesses.

#### Review of Literature

The studies by Spitz (1945) and Bowlby (1951) of the possible effects of parental deprivation on mental health, and the films, "A Two Year Old Goes to Hospital" (Bowlby *et al.*, 1952; Robertson, 1952a, 1952b) and "Going to Hospital with Mother" (Robertson, 1958a, 1958b), aroused wide interest in the results of separation of mother and child. Effect has been given to the views of these authors by a Ministry of Health (1959) report recommending the provision by hospitals of visiting and accommodation facilities which would lessen the incidence of separation and its alleged results. Riley *et al.* (1965) described facilities provided in a general hospital which are the logical development of this practice.

Little has been written about the desirability of infants or children accompanying their mothers when the latter are admitted to psychiatric hospitals.

Douglas (1956) admitted six psychotic mothers with their babies to the neurosis ward at the West Middlesex Hospital and concluded that the practice should be extended.

Main (1958) at the Cassel Hospital first admitted a mother with her child in 1948 and started to admit puerperal cases with their children in 1955, but did not admit those with severely disturbed psychotic states. He referred to "the twin dangers of separating mother and child, first, and more obvious, to the child, and second, but as fateful, to the mother's confidence in her future capacity as a mother."

Baker *et al.* (1961) reported a series of 20 puerperal schizophrenic mothers admitted with their babies to Banstead Hospital. He believed that to deprive such a mother of her child lessens her chances of recovery.

Glaser (1962) described the early stages of the development of the unit referred to in the present study.

Grunebaum and Weiss (1962-3) reported a series of 12 psychotic mothers admitted with their babies to the adult wards of the Massachusetts Mental Health Centre. They referred to the usual practice of separating mother and child

as likely to confirm the mother's belief that she is harmful to the child, and claimed that joint admission makes a substantial contribution to the mother's recovery.

Fowler and Brandon (1965) reported a series of 34 mothers with puerperal mental illness admitted with their children to the Pastures Hospitals. They thought that this procedure hastens recovery.

None of the above communications establishes a statistically valid case for the positive value of mother and baby units in the treatment of puerperal mental illness.

#### Theoretical Considerations

The studies by Spitz (1945) and Bowlby (1951) were mainly concerned with the effects of separation on the child—but separation also has effects on the mother. Spence (1946) suggested that if the mother is to be able to identify with the baby sufficiently to respond to its primary needs she must have the constant reassurance of its healthy development, and the pleasure and satisfaction of knowing that this development is the result of her care. The study of animal behaviour shows that releasers are essential for proper development of instinctual reactions.

Childbirth, in addition to being an emotionally satisfying experience, can also be a stress, one factor in which is the sudden need to make a relationship with a completely dependent being. This relationship is complicated by the fact that the infant is the receptacle for projections by the mother of her own repressed infantile feelings. She may become rejecting and hostile to the baby, who is felt to be bad. This may lead to infanticidal ideas or anxiety that the baby is ill because of her hostile feelings. In consequence the mother feels inadequate and guilty about being unable to cope with what seems to her a difficult baby.

When such a mother is admitted with her baby she can often be helped with these difficulties, whereas separation from her child can confirm her belief that she is harmful to it.

#### Details of Present Study

*Details of Setting.*—The setting has already been described by one of us (Glaser, 1962), who was in charge of the unit for the major portion of the time of this study. The unit consisted of 10 single rooms, a nursery, play-room, and communal sitting-room on the ground floor of a ward in Shenley Hospital. Two ward sisters and two assistant nurses were permanently attached to it, working on opposite shifts. In addition, two student nurses were attached for periods of three months.

*Selection of Patients for Present Study.*—At first the policy of the unit was to offer admission to any mother whose illness required treatment in hospital and in whose case separation from her child appeared likely to be harmful to either or both.

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This resulted in the admission of patients with, for example, long-standing neurotic or personality disorders or schizophrenic states which had no relation to pregnancy or the puerperium. Of the 193 mothers admitted during the period of this study, 78 were in this category. The patients selected for inclusion in this study were those admitted between August 1959 and May 1965 whose illness clearly started during pregnancy or within 12 months of childbirth. These numbered 115. With them were admitted 131 children, of whom 16 were siblings.

**General Data Relating to 115 Patients.**—The average age of the patients on admission was 28.3 years and of the children 13 weeks. Five were unmarried; 61 were primiparae. The average duration of illness before admission was 12 weeks. In 17 cases the illness started during pregnancy, in 81 within four weeks of delivery, in 14 within 24 weeks, and in 3 within 48 weeks. Twenty patients had 24 previous puerperal mental illnesses, 28 had 32 previous non-puerperal mental illnesses, and seven had both.

**Diagnostic Categories.**—Despite the difficulties of defining clinical categories, patients in the present series were categorized as shown in Table I. Our cases confirm that there is no specific mental illness connected with pregnancy or the puerperium (Foundeur *et al.*, 1957; Martin, 1958; Seager, 1960).

TABLE I.—*Diagnostic Categories*

Schizophrenic	Manic	Depressive	Neurotic
32 (27.8%)	12 (10.4%)	69 (60%)	2 (1.7%)

## Treatment

Antidepressants, tranquillizers, E.C.T., and supportive psychotherapy were used as appropriate. Martin (1958) and Baker *et al.* (1961) gave E.C.T. to 94.6% and 100% respectively of their patients. In the present series only five patients were given E.C.T. and seven had no physical treatments of any kind.

We found E.C.T. useful in those cases where there is a high suicide risk, and it is sometimes the most appropriate means of controlling a particular disturbance of behaviour that presents an urgent problem to the unit as a whole. Some manic behaviour comes into this category. Apart from such cases, antidepressants or phenothiazines or a combination of both constitute adequate physical treatment.

Psychological modes of treatment included a weekly group therapy session for 8 to 10 patients which aimed to provide understanding and toleration by them of each other's problems, as well as greater insight into their own. There were also frequent staff discussions, the aim being to provide a social situation which was therapeutic. Some patients were given individual supportive or interpretative psychotherapy.

An occupational therapist was not attached to the ward, as it was felt that the care of the babies constituted adequate occupation in itself. The patients did their own cooking, the hospital providing the raw materials. They also did the ward cleaning, no ward maid being attached to the unit.

The babies slept in their mothers' rooms, unless the mother was acutely disturbed, in which case the baby slept in the nursery for the first few nights. An essential part of the treatment regimen was the encouragement of the mother to assume complete responsibility for the care of her infant as quickly as possible. The staff assumed a role of supportive availability, and tried to avoid taking over the care of the babies. It was noticeable that many mothers who tended to neglect themselves kept their babies clean and well-fed.

## Emotional Problems of Staffing

After some initial apprehension in staff, acutely disturbed patients were admitted to the ward, and it was seen that it was unwise to make predictions based on diagnostic category or

degree of disturbance about the ability of a mother to care for her baby. Some grossly psychotic mothers cared devotedly for their children, while some neurotic mothers took little interest in them. As Baker (1962) says, the capacity of a psychotic mother to relate to her baby may remain when all other relationships have failed.

When the unit opened all staff were anxious about the risk of infanticide, and this fear initially caused a reluctance to accept severely disturbed patients. The fact that all patients had single rooms led to difficulty in observation which accentuated this fear. However, no case of infanticide occurred in the unit. It was agreed policy that no actively infanticidal patient should be admitted. In fact no such case presented for admission, and it would not now be considered necessary to exclude such cases from the unit.

The role of the nursing staff was a difficult one. It was necessary for them to check their own strong maternal feelings and at the same time to encourage the mothers to care for and handle their babies.

## Length of Stay

Length of stay depends on the stability of the patient's social background and material considerations such as income and housing conditions as well as an efficacy of treatment. Figures for the present and other series are shown in Table II. Martin's patients were admitted without their babies. Her figures include a schizo-affective category, the average length of stay of which was 12.8 weeks. The series of Baker *et al.* was confined to schizophrenics. They found that 20 schizophrenic mothers admitted without their babies to an ordinary admission ward stayed for an average of 16.8 weeks. Fowler and Brandon do not state length of stay according to diagnosis. They find that an unstated number of patients admitted without their babies "stayed an average of 10.7 weeks."

TABLE II.—*Average Length of Stay in Weeks*

	Present Series	Baker <i>et al.</i> (1961)	Fowler and Brandon (1965)	Martin (1958)
No. of cases .. ..	115	20	34	75
Period of survey ..	1959-65	1959-61	1963-5	1947-57
Length of stay (weeks):				
All types .. ..	7		6.85	10.2
Affective .. ..	7.7			5.5
Schizophrenic ..	6.4	10.8		12.4

Ministry of Health figures relating to the period of stay of all patients discharged from mental hospitals are available for the years 1959, 1960, and 1964. These show that the median period of stay of such patients has fallen over the period 1959-64, and for each of the three years is as follows: 1959, 48 days (6.85 weeks); 1960, 45 days (6.4 weeks); 1964, 40 days (5.7 weeks).

The figures available for comparison suggest that mothers suffering from puerperal mental illness admitted with their babies stay for a shorter period of time than those admitted without their babies, with the exception of Martin's affective cases. This point is discussed below.

## Condition on Discharge

The chief aim of the unit is to establish or restore a mother-child relationship beneficial and satisfying to both. Accepting the subjective difficulties in assessing psychiatric states, we felt

TABLE III.—*Condition on Discharge—Present Series—112 Cases*

No residual symptoms—able to care for child ..	50 (44.6%)
Residual symptoms:	
Able to care for child .. ..	50 (44.6%)
Needing help to care for child .. ..	6 (5.4%)
Unable to care for child .. ..	6 (5.4%)

it was possible objectively to observe that a mother on leaving was able to care for her child independently, or was emotionally dependent on the support of staff or relatives, or was incapable of offering her child any worth-while care (see Table III).

Two patients committed suicide while under treatment. One patient was found drowned in her bath in the unit. A verdict of death from misadventure was returned, the coroner's pathologist expressing the opinion that the patient had had a syncopal attack. Neither patient who committed suicide was in the unit at the time. One was at home on weekend leave, having made an apparently good recovery. The other had been temporarily transferred to another ward because of a serious suicidal attempt. She committed suicide outside the hospital while in a state of apparent remission, having obtained permission to leave the ward. Neither of the two deaths due to suicide was known to patients in the unit.

The 20 patients of Baker *et al.* (1961) admitted to their mother and baby unit all returned home "able to take full care of their babies" and with an average score of 13.6 on the Wittenborn rating scale, whereas only 13 of the mothers from the ordinary admission ward were able to do so, their average Wittenborn score being 17.6. Fowler and Brandon (1965) gave no details of their patients' condition on discharge. Of Seager's (1960) 42 cases, admitted without their babies, 21 (53.84%) were recovered on discharge, 14 (35.89%) were relieved, and 4 (10.25%) unimproved.

In Martin's (1958) series of 75 cases admitted without their babies it is not clear what was the state on discharge of her 28 cases of affective psychosis. She says: "The immediate prognosis of affective disorders in the puerperium is excellent and full recovery can be expected with electroplexy." Of her 46 other patients discharged, 26 were recovered and 20 were much improved.

Seager and Martin, in series which are clinically comparable with the present one, appear to have obtained results on discharge which are respectively as good as or better than those obtained in the present series.

### Follow-up

All patients were written to and asked if they would be willing to be interviewed, and 33 were interviewed by us. In the case of those who did not reply, the patient's general practitioner was written to and asked to provide information. In the case of those patients who had transferred to another doctor the appropriate executive council was written to, and in a certain number of cases it was possible to discover the new doctor's address, who was then asked to provide information. It was considered that to call on patients who had not replied was not justified.

The results of this method of follow-up are set out in Table IV. The categories used in Table III were considered inappropriate to the more complex situations and responsibilities facing the patient after discharge.

These assessments are imprecise, and, in varying degrees, subjective. They took into account the patient's competence as mother and housewife, and the effect on this competence of any symptoms she had at the time of follow-up.

The follow-up was carried out between March 1965 and November 1966. The average time between date of discharge and follow-up was 32 months.

TABLE IV.—*State of Adjustment at Time of Follow-up*

	Good	Moderate	Poor	Totals
Ascertained by:				
Interview ..	20	10	3	33 (40.7%)
Letter from doctor ..	17	15	8	40 (49.3%)
Letter from patient ..	5	2	1	8 (9.8%)
	42 (51.8%)	27 (33.3%)	12 (14.8%)	81

Of the 112 patients discharged 81 (72%) were followed up as indicated. This number is insufficient to allow any valid conclusions to be drawn from the data.

One patient died of pulmonary embolism in hospital. She had been admitted to the mother and baby unit in a manic state, and was readmitted with depression four months after her discharge. She died within three days of having modified E.C.T. It is not possible to say if there was a causal relation between the modified E.C.T. and her pulmonary embolism.

Martin (1958) had no deaths from pulmonary embolism associated with E.C.T. given to 72 of her 75 patients. Twelve of these patients had E.C.T. within one month of confinement. She gives four references to the alleged risk of embolism from pelvic vein thrombosis if E.C.T. is given within one month after confinement, but she can trace in the literature only one case of embolism after E.C.T. She concludes that it is safe to give E.C.T. within one month of confinement provided there is no evidence of thrombophlebitis.

### Mortality

There was in our series a death rate of 2.6% in patients under treatment for the initial illness and a known death rate of 3.5% if the follow-up period is included. Martin's comparable figures were 1.3% and 2.6% respectively. Tetlow (1962), in a study of 67 consecutive female admissions suffering from mental illness complicating child-bearing, found a 9% mortality. His patients were admitted between October 1947 and May 1950. Excluding deaths occurring during a 12-year follow-up, his mortality was 5.9%. Hemphill (1952) found five (4.3%) deaths in 116 cases of puerperal mental illness admitted to Bristol mental hospitals between January 1938 and June 1948—one was due to suicide and four were due to toxic delirium. C. Protheroe (personal communication, 1968) had no deaths in a series of 67 mothers admitted with their babies since 1964 to St. Nicholas Hospital, Newcastle upon Tyne. In 103 patients admitted to our mother and baby unit from 1 May 1965 to 1 January 1968 there was one death, a suicide while under treatment.

The mortality in our series may appear high, but the number of cases studied is not large enough to allow any conclusions to be drawn.

### Discussion

The present study confirms that it is possible to admit with their children mothers suffering from any type and degree of puerperal mental illness, and confirms that by offering them graduated responsibility in a supportive setting, while at the same time using all relevant physical and psychological methods of treatment, it is possible to get a satisfactory result in terms of the mother-child relationship in a high proportion of cases (89% in the present series) at time of discharge. As a result of our experience we believe that the procedures described constitute an advance in the treatment of puerperal mental illness, though the present study does not make a statistically validated case for the positive value of such procedures.

### Criteria of Selection for Admission

The number of patients presenting for admission to our unit was in excess of available beds, which are most conveniently and efficiently provided in a separate unit. It is therefore important to establish criteria of selection for admission.

In our new unit of five beds opened in May 1965 in a staff house in the hospital grounds we have given priority for admission to the patient with unequivocal puerperal psychosis, preferably occurring within a stable marriage, and without material obstacles to discharge on recovery. We give a lower priority to patients whose puerperal illness is associated with long-

standing neurotic or personality disorders and consequent social problems. They do less well and stay longer.

Applying these priorities and maintaining a treatment regimen similar to that used in the present series, we find that in the 97 patients admitted and discharged between 1 May 1965 and 13 November 1967 the average duration of stay has dropped from 7 weeks to 4.3 weeks.

### Evaluation and Possible Prospective Studies

The good results obtained by Martin (1958) in treating mothers admitted without their babies and the lack of studies which establish statistically the positive value of mother and baby units suggest the desirability of attempting a statistical evaluation of such units. There are non-measurable and therefore non-controllable variables in the treatment situation which make it difficult to assess the effect of the presence or absence of the child. The history of psychiatric treatment shows many examples of units with a high staff:patient ratio and high morale producing good therapeutic results which were wrongly attributed to a specific factor in the treatment situation—for example, insulin—instead of to the interaction of staff and patients. Undoubtedly the presence of babies in a unit tends to produce a high degree of interest, concern, and involvement in staff. Such staff attitudes can obviously exist in other treatment situations but cannot easily be measured.

Despite these difficulties, we feel that further reports of others' experiences and collaboration between psychiatric hospitals in providing adequate series of patients for comparison of the results of different patterns of management should be considered. The study of such series might include a comparison of the psychological and physical development of the children over a period of at least five years.

### Summary

A unit for mothers whose mental illness arose during pregnancy or 12 months after confinement is described.

Certain significant contributions to the development of concern about the possible harm resulting from separation of mother and child are noted, and some theoretical considerations are advanced as a basis for the use of mother and baby units.

In a series of 115 mothers and their babies admitted to this unit 32 mothers were diagnosed as schizophrenic, 12 as manic,

69 as depressive, and 2 as neurotic. The average length of stay was seven weeks. On discharge 89% were able to care adequately for their children.

Comparisons with other series admitted with and without their babies do not establish a statistically based case for the positive value of mother and baby units. The difficulties of doing so are noted and suggestions made about possible solutions.

As a result of our experience we, whose orientation is towards immediate benefit to the mother rather than the child, believe that these units constitute an advance in the treatment of puerperal mental illness.

Our thanks are due to the Management Committee and the matron of Shenley Hospital, who supported the work, and particularly to Sisters Arnold and Orpin, without whose close involvement the treatment programme could not have been carried out.

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## MEDICAL EDUCATION

### Conference on Vocational Training for General Practitioners

[FROM A SPECIAL CORRESPONDENT]

Opening a conference on vocational training for general practitioners held by the Royal College of General Practitioners in London on 5 June, the chairman of the morning session, Sir GEORGE GODBER (Chief Medical Officer, Ministry of Health), said that in 1948 the scale on which medical practice would evolve was not foreseen. The ladder concept dominated thinking—you went into general practice if you fell off the ladder. The Nuffield Conference in 1961 inspired the concept of continual learning and vocational training for all doctors, for which the Central Committee for Postgraduate Medical Education now provided the central stimulus. The pace of change was increasing. Health centres were being demanded; 60 were

going up at present, and by 1970 there would be six times as many as there had been in 1965. Attachment of nursing staff to general practice was increasing and few groups would be without nurses in five years' time. Planned preparation for general practice was needed, with willing graduates properly prepared rather than aimlessly meandering through dead-end junior hospital jobs.

#### Plan and Practice

Dr. JOHN HORDER (Chairman of the Vocational Training Subcommittee, R.C.G.P.) said that there was a blueprint for vocational training ready to be imple-

mented. The concept of the medical generalist was now generally accepted, though if an acute shortage of generalists occurred it might unintentionally break down. The general practitioner's role was one of the most difficult in medicine, and if we wanted good ones we must train them after registration. At present only one in eight doctors entered general practice through vocational training. Because of the current shortage of young entrants to general practice the salaries they could command were well above those of registrars in hospital, and vocational training was seen by some senior general practitioners as a menace rather than a blessing. Provision of vocational training for all would need 2,000 training posts in hospital and